Applicable To:
☑ Medicaid – Kentucky

Claims and Payment Policy: Emergency Department Evaluation and Management Overcoding (Kentucky) (LT194)

Policy Number: CPP-143

Original Effective Date: 10/21/2019
Revised Date(s): 11/13/2019, 5/12/2020, 7/17/2020

BACKGROUND

Evaluation and Management Services (E/M) is defined as physician-patient encounters that are translated into five-digit CPT codes for billing purposes. Different E/M codes exist for different patient encounters such as office visits, hospital visits, emergency room visits, and home visits. Each patient encounter has different levels of care. Clear and concise medical record documentation is critical to providing patients with quality care and is required for providers to receive accurate and timely payment for furnished E/M services. E/M medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history. E/M codes (99201-99499) describe a provider's service to a patient including evaluating the patient's condition(s) and determining the management of care required to treat the patient.

RATIONALE

In 2012, the Office of Inspector General (OIG) reported in their article, *"OIG, Coding trends of Medicare Evaluation and Management Services"* that from 2001 to 2010, physicians increased billing of higher level E&M services. Consequently, higher level E&M services are reimbursed at a higher level of reimbursement. Furthermore, the report revealed that E&M services are 50% more likely to be paid in error as a result of miscoding or coding errors.
As a result of this study, the OIG determined that 26% of Medicare claims reviewed were billed with a higher intensity E&M code than supported by the medical documentation.

POSITION STATEMENT

The purpose of this policy is to discuss the appropriate assignment of moderate to high complexity E/M services with an emphasis on medical decision making as a key component of the assignment process.

The selection of an appropriate Evaluation and Management Service (E&M) is based upon seven components pertinent to the patient's encounter with the provider: 1) history, 2) examination, 3) medical decision making, 4) counseling, 5) coordination of care, 6) nature of presenting problem, and 7) time. Medical decision making is based upon the physician's complexity of establishing a diagnosis and/or selection of options to manage the patient's health. Three of these components-- **the patient's history, physical examination and medical decision-making** are the most important factors in determining the correct level of E&M service that a provider should bill for any given patient encounter. The remaining four components are considered contributing elements.

Medical decision-making is a key component necessary to assign the appropriate level of E&M visit type. There are four types of medical-decision making:

- Straight-forward
- Low complexity
- Moderate complexity
- High complexity

Medical decision making is defined by the complexity of a physician's work that is necessary to establish a diagnosis and/or to select a healthcare management option. When determining the level of E&M service to assign, the physician must consider 1) the number of possible diagnoses or health management options, 2) the amount or the complexity of medical records, diagnostic testing or any other information that must be reviewed and evaluated, and 3) the risk of complications, morbidity and/or mortality.

The following chart describes each of the four types of medical-decision making listed above:

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	***Straightforward***
Limited	Limited	Low	***Low Complexity***
Multiple	Moderate	Moderate	***Moderate Complexity***
Extensive	Extensive	High	***High Complexity***

E&M services are assigned based on the medical appropriateness/necessity of the physician-patient encounter and must meet the specific requirements of the Current Procedural Terminology (CPT) code billed on the claim. Physicians should not submit a CPT code for a higher intensity E&M service if the circumstances surrounding the physician-patient encounter do not support medical decision making of moderate to high complexity.

Application

Physician and non-physician practitioners who provide:

- Office and other outpatient services
- Hospital observation
- Inpatient services
- Consultations
- Emergency Department Visits
- Nursing Facility Services
- Domiciliary Services
- Home Services

Post Pay Review

If you do not agree with a payment determination, you have the right to file an appeal by submitting the medical record that supports additional reimbursement. WellCare will review the submitted medical record(s) to assess the intensity of service and complexity of medical decision-making for the ED E/M services provided.

Appeals
Providers will have appeals rights on all E/M recode claims for reason code LT194.

Please submit appeals to WellCare Health Plans, ATTN: CCR, P.O. Box 31394 Tampa, FL 33631-3394. Please refer to WellCare's Quick Reference Guide (QRG) for additional instructions.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy. If State policies **do not specify coverage provisions**, then the State will follow National coverage guidelines as outlined in this policy

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

E/M DOCUMENTATION REQUIREMENTS

Number of Diagnoses and/or Health Management Options

This is based on the number and types of problems addressed during the patient encounter, the difficulty in establishing a diagnosis and the complexity of health management decisions made by the provider.
For each patient encounter documentation should include:

- An assessment, clinical impression or diagnosis
- If the patient presents with an established diagnosis, documentation must include whether or not the condition is improved, well controlled, resolving, resolved, inadequately controlled, worsening or failing to improve.
- If the patient presents with a problem without a diagnosis, the provider should document their clinical impression in the form of a "possible," "probable," or "rule out" diagnoses.
- Initiation of a treatment plan or changes in the treatment plan.
- If a referral or consultation is sought, the physician should document to whom or where the consultation is made or from whom the consultation was requested.

Document the Amount and/or Complexity of Data to Be Reviewed

Providers should base documentation on the types of diagnostic testing ordered and reviewed. Obtaining old medical records and history from sources other than the patient increase the amount of complexity and data reviewed.
For each patient encounter documentation should include:

- Diagnostic tests or services that were ordered, performed, planned or scheduled during the E&M encounter.
- Review of any diagnostic tests or services performed. Medical records should clearly support that the tests were reviewed.
- Determination to obtain old medical records or seek health information from someone other than the patient.
- Significant findings from old medical records and/or receipt of additional history from the family
- The results of discussion diagnostic testing with another physician who performed the testing.
- Direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician.

Risk of Complications, Morbidity and/or Mortality

When determining the risks of complications, morbidity or mortality, the physician must assess the risks associated with the presenting problems, diagnostic procedures and the possible health management options.
For each patient encounter, documentation should include:

- Comorbidities/underlying diseases contribute to the risk of complications, morbidity and mortality. This increases the complexity of medical decision making.
- Documentation of provider orders, scheduling or planning a surgical or invasive procedure at the time of the E&M visit, including the type of procedure.
- Documentation of any surgical or invasive diagnostic procedures performed at the time of the E&M encounter.
- The referral for or a decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

Provider Documentation

When documenting the medical visit, physicians must ensure that the medical record documentation is:

- Intelligible - The medical record should include the date and legible identity (signature) of the physician who furnished the service. The signature for each entry must be legible and should include the practitioner's first and last names and credentials.

- Concise - The care the patient received and related, facts, findings and observations about the patient's health history.
- Supports the medical necessity reason for the visit and the level of E&M service billed.
- The medical record must be complete.

Medical Record Authentication

Wellcare requires that services provided to the member must be authenticated by the author of the medical record. Medical records must be signed prior to submission of the claim. The signature must be handwritten or electronically signed.

CODING & BILLING

CPT/HCPCS Code	COMPLEXITY LEVEL	Descriptor
99284	Medium-High	Emergency Department Visit
99285	High	Emergency Department Visit

E/M GLOSSARY

Chief Complaint (CC)	A concise statement describing the symptoms, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words and documented in the medical record
Coordination of Care	Coordination of care is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of healthcare services.
Counseling	A conversation with the patient and/or the family/patient's guardian concerning test results, treatment, and education.
Established Patient	A patient who has received professional services within the past three years by the same provider or another provider in the same group with the exact same specialty and subspecialty
Evaluation and Management Services	Physician-patient encounters that are translated into five-digit CPT codes for billing purposes. Different E&M codes exist for different patient encounters such as office visits, emergency room visits, hospital visits, and home visits. Each patient encounter has different levels of care.
Examination	The levels of E/M services are based on four types of examination: **Problem Focused** – A limited examination of the affected body area or organ system **Expanded Problem Focused** – A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s) **Detailed** – An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s) **Comprehensive** – A general multi-system examination or complete examination of a single organ system (and other symptomatic or related body area(s) or organ system(s) – 1997 documentation guidelines)
Family History	A review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk
History	The history component is comprised of the following elements: • Chief complaint or reason for the encounter (CC). • History of Present Illness (HPI). • Review of systems (ROS). • Past, family, and/or social history (PFSH).
History Present Illness (HPI)	A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present
Medical Decision-Making (MDM)	The complexity of establishing a diagnosis and/or selecting a management option, as measured by the following documentation**:**

	1. "The number of possible diagnoses and/or the number of management options that must be considered 2. The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed. The risk of significant complications, morbidity, and/or mortality, as well as co-morbidities, associated with the patient's presenting problem(s), diagnostic procedures(s), and /or possible management options.
Nature of the Presenting Problem	A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter.
New Patient	A patient who has not received any professional services within the past three years by the same provider or another provider in the same group with the exact same specialty and subspecialty
Past History	A review of the patient's past experiences with illnesses, operations, injuries and treatments
Professional Services	Face-to-face services rendered by physicians or other qualified healthcare professional who may report E/M services within the same group practice and of the exact same specialty and subspecialty.
Review of Systems (ROS)	An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. For the purpose of ROS, the following systems are recognized: eyes, ear nose, mouth, throat, respiratory, genitourinary, integumentary (skin and/or breast), psychiatric, hematologic/lymphatic, constitutional (e.g. fever, weight loss) cardiovascular, gastrointestinal, musculoskeletal, neurological, endocrine, and allergic/immunologic
Social History	An age appropriate review of past and present activities
Time	Face-to-face duration for office and other outpatient visits and unit/floor time for hospital and other inpatient services.

REFERENCES

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2. Centers for Medicare and Medicaid Services (CMS)
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8. Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners. Retrieved July 6, 2020 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com.

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
10/21/2019	• Approved by RGC